

Quarterly Notice of Medicaid Claims Defects

Bar Code Required - Place Bar Code Here

Report may be based on Medicaid Claims
OR Medicaid Claims Lines.

Indicate the basis you are using:

choose ☐ Medicaid Claims
only one ☐ Medicaid Claim Lines

Report total Medicaid
claims/claim lines
received in report period.Report total number of
second denied
Medicaid claims/claim
lines in report period.Report second denied
Medicaid claims/claim lines as
a percentage of total claims
processed in report period.

Use the formats below to prepare the Report and Summary using your office information systems.

Provide report in black print on 8 1/2" x 11" white sheets. Type must be easily readable, such as Arial 7pt. or larger.

Number pages as Page X (page number) of Y (total pages attached).

Report Claim or Claim Line rejected a SECOND TIME. Do not report Claims/Claim Lines rejected only once!

Label columns in the order shown below. Use a line for each claim or claim line with defect (rejected twice). Use at least 3 spaces or a vertical line to separate columns. Record all dates in MM-DD-YY format.

REPORT FORMAT: Please sort report in ascending order based on Provider Federal Employer ID (FEIN)

QHP Claim Identifier	Provider name	Provider type code	Provider's Federal Employer ID (FEIN)	Date of Service	Date claim was received	Date claim rejection notice sent to provider	Rejection code (FIRST rejection)	Date SECOND claim was received	Date SECOND claim rejection notice sent to provider	Rejection code (SECOND rejection)
S123456	Sample Clinic	XX	222222222	02-22-22	03-22-22	04-22-22	123456	05-22-22	06-22-22	654321

Each reported claim should look similar to this example

SUMMARY FORMAT: Label columns as shown below to prepare a Summary by Rejection Code. Number pages as Page X (page number) of Y (total pages attached). Please sort summary by "Second denied Medicaid claims as a percentage of total..." (last column) in descending order (highest percentage first, lowest percentage last)

Rejection Code	Description of rejection code	Number of Medicaid claims denied a second time in report period	Second denied Medicaid claims as a percentage of total second denied claims for report period
MEMNEL	Member not eligible at date of service	29	4.27%

Each line should look similar to this example

When this form is complete, attach report and summary.

Send to: Office of Financial and Insurance Services
Health Plans Division
611 W. Ottawa St.
P.O. Box 30220
Lansing MI 48909-7720

Mail or deliver allowing adequate time for filing to arrive at OFIS on or before the quarterly due date.

HMO name

Report is due quarterly even if there were no defective claims for the quarter.

Indicate which
report you are filing.

- ☐ Q1 (Jan, Feb, Mar) DUE April 30
☐ Q2 (Apr, May, Jun) DUE July 31
☐ Q3 (Jul, Aug, Sep) DUE October 31
☐ Q4 (Oct, Nov, Dec) DUE January 31

Report Year 20_____

Public Act 187 of 2000 amends the Social Welfare Act (Public Act 280 of 1939) to add requirements for timely payments to providers for covered health care services rendered to persons enrolled in Medicaid who are members of a qualified health plan (QHP). MCL 400.111i(2)(i) requires that a qualified health plan notify the health professional or facility and the commissioner of a defect in a claim if it is not payable the second time it has been submitted, regardless of the reason.

Certification:

I certify that I have thoroughly examined this report. The information contained in and attached to it is complete and correct to the best of my knowledge and belief.

Signature of HMO's authorized representative

Date signed

Signer's name and title (please type or print)

Contact person name and phone number (include area code)

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Contact person's EMail address



Michigan Department of Labor & Economic Growth

Visit OFIS online at: www.michigan.gov/ofis Phone OFIS toll-free at: 1-877-999-6442

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